AGREEMENT FOR SERVICES #4206
Drug Medi-Cal Organized Delivery System Services

THIS AGREEMENT is made and entered into by and between the County of El Dorado, a political subdivision of the State of California (hereinafter referred to as "County") and Progress House, Inc., a California Domestic Non-Profit Corporation, duly qualified to conduct business in the State of California, whose principal place of business is 2844 Coloma Street, Placerville, CA 95667 (*Mailing: P.O. Box 1666, Placerville, CA 95667*), (hereinafter referred to as "Provider");

RECITALS

WHEREAS, County has determined that it is necessary to obtain a Provider to provide Drug Medi-Cal Organized Delivery System Services (DMC-ODS); and

WHEREAS, Provider responded to a Response for Qualifications #19-918-004, wherein Provider represented to County that it is specially licensed, qualified, trained, experienced, expert and competent to perform the special services required hereunder and County has determined to rely upon such representations; and

WHEREAS, the parties hereto have mutually agreed that existing Agreement #002-S1811 (FENIX #8) shall automatically terminate and be replaced upon execution of this Agreement for Services #4206; and

WHEREAS, it is the intent of the parties hereto that such services be in conformity with all applicable federal, state and local laws; and

WHEREAS, County has determined that the provision of these services provided by Provider is in the public's best interest, and that these services are more economically and feasibly performed by outside independent Providers as well as authorized by El Dorado County Charter, Section 210 (b) (6) and/or Government Code 31000;

NOW, THEREFORE, County and Provider mutually agree as follows:

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Exhibits

1. **Intergovernmental Agreement (IGA) #18-95146**
2. Substance Abuse Prevention and Treatment Block Grant (SABG) #17-94126
3. Case Management Services
4. Intensive Outpatient Services Level 2.1
6. Outpatient Services Level 1.0
7. Recovery Residence Services
8. Recovery Services
9. Residential Services
11. Network Provider Performance Standards and Measures
12. Sliding Fee Scale
13. HIPAA Business Associate Agreement

ARTICLE I – Responsibilities and Services

1. **County Responsibilities:**
   County shall be responsible for the following:
   A. Annual site inspection of all Provider-operated or Provider-contracted sites located within El Dorado County to evaluate the work performed or being performed hereunder, including subcontracted supported activities and the premises in which it is being performed. For Provider-operated or Provider-contracted sites located outside El Dorado County, the County may accept the annual site inspection documentation prepared by the host county if all El Dorado County Compliance Monitoring requirements are contained within.
   B. Monitoring of invoices and services to verify adherence to the funding requirements.
   C. Monitoring of program to verify adherence to terms and conditions pursuant to this Agreement.

2. **Authorization of Services**: The following services may only be provided if County refers a client to Provider via County's written treatment authorization form available at https://www.edcgov.us/Government/hhsa/Pages/hhsa_contractor_resources.aspx:

   A. AB 109 Treatment Services
   B. Additional Case Management Services per Exhibit 3
   C. Recovery Residences Services per Exhibit 7
   D. Residential Services per Exhibit 9
   E. Substance Abuse Prevention and Treatment Block Grant per Exhibit 2

3. **Scope of Services:** Provider agrees to furnish the personnel and equipment necessary to provide services as defined in Intergovernmental Agreement 18-95146, or as may be amended, (Exhibit 1), Substance Abuse Prevention and Treatment Block Grant (SABG) Agreement 17-94126, or as may be amended, (Exhibit 2), and Exhibits 3 through 11, as applicable, all of which are attached hereto and incorporated by reference herein, as well as substance abuse testing and client progress reports. To the extent that the terms and conditions of the Intergovernmental Agreement and the SAGB Agreement conflict, the terms and condition of the Agreement with the most stringent provisions shall prevail.

   In addition, all services provided pursuant to this Agreement shall be performed in accordance with the following requirements, or as may be amended, all of which constitute part of this Agreement, available at https://www.edcgov.us/Government/hhsa/Pages/hhsa_contractor_resources.aspx

   A. Alcohol and/or Other Drug Program Certification Standards
   B. Drug Medi-Cal Billing Manual
   C. El Dorado County DMC-ODS Practice Guidelines
   D. El Dorado County Recovery Residences Provider Guidelines
   E. Minimum Quality Drug Treatment Standards – DMC
   F. Minimum Quality Drug Treatment Standards – SABG
   G. Perinatal Practice Guidelines
   H. Youth Treatment Guidelines

4. **Provision of Services:**
   The following requirements shall apply to the Provider, and the provider staff:
   A. Professional staff shall be licensed, registered, certified, or recognized under California scope of practice statutes. Professional staff shall provide services within their individual scope of practice and receive supervision required under their scope of practice laws. Licensed Practitioners of the Healing Arts (LPHA) include:
      1. Physician
      2. Nurse Practitioners
      3. Physician Assistants
      4. Registered Nurses
      5. Registered Pharmacists
      6. Licensed Clinical Psychologists
      7. Licensed Clinical Social Worker
      8. Licensed Professional Clinical Counselor
      9. Licensed Marriage and Family Therapists
      10. Licensed Eligible Practitioners working under the supervision of Licensed Clinicians
   B. Non-professional staff shall receive appropriate onsite orientation and training prior to performing assigned duties. A professional and/or administrative staff shall supervise non-professional staff.
   C. Professional and non-professional staff are required to have appropriate experience and any necessary training at the time of hiring. Documentation of trainings, certifications, and licensure shall be contained in personnel files.
   D. Physicians shall receive a minimum of five hours of continuing medical education related to addiction medicine each year.
   E. Professional staff (LPHAs) shall receive a minimum of five hours of continuing education related to addiction medicine each year.
   F. Registered and certified SUD counselors shall adhere to all requirements in Title 9, Chapter 8.

5. **Services for Adolescents and Youth:** Assessment and services for adolescents will follow the ASAM adolescent treatment criteria.

6. **Confidentiality:** All Substance Use Disorder (SUD) treatment services shall be provided in a confidential setting in compliance with 42 Code of Federal Regulations (CFR), Part 2 requirements.

7. **Perinatal Services:**
   A. Perinatal services shall address treatment and recovery issues specific to pregnant and postpartum women, such as relationships, sexual and physical abuse, and development of parenting skills.
   B. Perinatal services shall include:
      1. Mother/child habilitative and rehabilitative services (i.e., development of parenting skills, training in child development, which may include the provision of cooperative child care pursuant to Health and Safety Code Section 1596.792).
      2. Service access (i.e., provision of or arrangement for transportation to and from medically necessary treatment).

3. Education to reduce harmful effects of alcohol and drugs on the mother and fetus or the mother and infant.
4. Coordination of ancillary services (i.e., assistance in accessing and completing dental services, social services, community services, educational/vocational training and other services which are medically necessary to prevent risk to fetus or infant).
5. Medical documentation that substantiates the beneficiary's pregnancy and the last day of pregnancy shall be maintained in the beneficiary record.
6. Provider shall comply with the perinatal program requirements as outlined in the Perinatal Practice Guidelines Fiscal Year 2018-19 as referenced in **ARTICLE I, Responsibilities and Services, Section 3, Scope of Services**.
7. Provider shall comply with the current version of these guidelines until new Perinatal Practice Guidelines are established and adopted.
8. The incorporation of any new Perinatal Practice Guidelines into this Agreement shall not require a formal amendment.

8. **Substance Use Disorder Medical Director:**
   A. The SUD Medical Director's responsibilities shall, at a minimum, include all of the following:
      1. Ensure that medical care provided by physicians, registered nurse practitioners, and physician assistants meets the applicable standard of care.
      2. Ensure that physicians do not delegate their duties to non-physician personnel
      3. Develop and implement written medical policies and standards for the provider.
      4. Ensure that physicians, registered nurse practitioners, and physician assistants follow the provider's medical policies and standards.
      5. Ensure that the medical decisions made by physicians are not influenced by fiscal considerations.
      6. Ensure that provider's physicians and LPHAs are adequately trained to perform diagnosis of substance use disorders for beneficiaries, and determine the medical necessity of treatment for beneficiaries.
      7. Ensure that provider's physicians are adequately trained to perform other physician duties, as outlined in this section.
   B. The SUD Medical Director may delegate his/her responsibilities to a physician consistent with the provider's medical policies and standards; however, the SUD Medical Director shall remain responsible for ensuring all delegated duties are properly performed.

9. **Provider Personnel:**
   A. Personnel files shall be maintained on all employees and volunteers/interns and shall contain the following:
      1. Application for employment and/or resume
      2. Signed employment confirmation statement/duty statement
      3. Job description
      4. Performance evaluations
      5. Health records/status as required by the provider, AOD Certification or Title 9
      6. Other personnel actions (e.g., commendations, discipline, status change, employment incidents and/or injuries)
      7. Training documentation relative to substance use disorders and treatment
      8. Current registration, certification, intern status, or licensure

9. Proof of continuing education required by licensing or certifying agency and program
10. Provider's Code of Conduct and for registered, certified, and licensed staff, a copy of the certifying/licensing body's code of conduct as well

B. Job descriptions shall be developed, revised as needed, and approved by the provider's governing body. The job descriptions shall include:
   1. Position title and classification
   2. Duties and responsibilities
   3. Lines of supervision
   4. Education, training, work experience, and other qualifications for the position

C. Written provider code of conduct for employees and volunteers/interns shall be established which addresses at least the following:
   1. Use of drugs and/or alcohol
   2. Prohibition of social/business relationship with beneficiaries or their family members for personal gain
   3. Prohibition of sexual contact with beneficiaries
   4. Conflict of interest
   5. Providing services beyond scope
   6. Discrimination against beneficiaries or staff
   7. Verbally, physically, or sexually harassing, threatening or abusing beneficiaries, family members or other staff
   8. Protection of beneficiary confidentiality
   9. Cooperate with complaint investigations

D. If a provider utilizes the services of volunteers and/or interns, written procedures shall be implemented which address:
   1. Recruitment
   2. Screening and Selection
   3. Training and orientation
   4. Duties and assignments
   5. Scope of practice
   6. Supervision
   7. Evaluation
   8. Protection of beneficiary confidentiality

E. Written roles and responsibilities and a code of conduct for the Medical Director shall be clearly documented, signed and dated by a provider representative and the physician.

10. **Beneficiaries Eligibility:**

A. All beneficiaries shall meet the following medical necessity criteria:
   1. The individual shall have received a diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM) Fifth Edition for Substance-Related and Addictive Disorders with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders or be assessed to be at risk for developing substance use disorder (for youth under 21).
   2. The individual shall meet the ASAM Criteria definition of medical necessity for services based on the ASAM Criteria.
   3. For beneficiaries in treatment prior to implementation of the DMC-ODS, the provider must conduct an ASAM assessment by the due date of the next updated treatment plan or continuing services justification, whichever occurs first.

a. If the assessment determines a different level of care, the provider shall refer the beneficiary to the appropriate level of care.

B. In addition the initial medical necessity determination, for an individual to receive a DMC-ODS benefit, shall be performed by a Medical Director or an LPHA. The Medical Director or LPHA shall evaluate each beneficiary's assessment and intake information if completed by a counselor through a face-to-face review or telehealth with the counselor to establish a beneficiary meets medical necessity criteria. After establishing a diagnosis and documenting the basis for diagnosis, the ASAM Criteria shall be applied to determine placement into the level of assessed services.

C. For an individual to receive ongoing DMC-ODS services, the Medical Director or LPHA shall reevaluate that individual's medical necessity qualification at least every six months through the reauthorization process and document their determination that those services are still clinically appropriate for that individual. For an individual to receive ongoing Opioid Treatment Program/Narcotic Treatment Program (OTP/NTP) services, the Medical Director or LPHA shall reevaluate that individual's medical necessity qualification at least annually through the reauthorization process and determine that those services are still clinically appropriate for that individual.

D. Provider shall be responsible for verifying the Medi-Cal eligibility of each beneficiary for each month of service prior to billing for DMC services to that beneficiary for that month. Medi-Cal eligibility verification should be performed prior to rendering service, in accordance with and as described in the DHCS DMC Provider Billing Manual. Options for verifying the eligibility of a Medi-Cal beneficiary are described in the Department of Health Care Services DMC Provider Billing Manual.

11. **Beneficiary Admission:**

A. Each provider shall include in its policies, procedures, and practice, written admission and readmission criteria for determining beneficiary's eligibility and the medical necessity for treatment. These criteria shall include, at a minimum:
   1. Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnosis
   2. Use of alcohol/drugs of abuse
   3. Physical health status
   4. Documentation of social and psychological problems.

B. If a potential beneficiary does not meet the admission criteria, the beneficiary shall be referred to an appropriate service provider.

C. If a beneficiary is admitted to treatment, the beneficiary shall sign a consent to treatment form.

D. The Medical Director or Licensed Practitioner of Healing Arts (LPHA) shall document the basis for the diagnosis in the beneficiary record.

E. All referrals made by the provider staff shall be documented in the beneficiary record.

F. Copies of the following documents shall be provided to the beneficiary upon admission:
   1. Beneficiary rights, share of cost if applicable, notification of Drug Medi-Cal (DMC) funding accepted as payment in full, and consent to treatment.

G. Copies of the following shall be provided to the beneficiary or posted in a prominent place accessible to all beneficiaries:
   1. A statement of nondiscrimination by race, religion, sex, ethnicity, age, disability, sexual preference, and ability to pay.
   2. Complaint process and grievance procedures.

3. Appeal process for involuntary discharge.
4. Program rules and expectations.

H. Where drug screening by urinalysis is deemed medically appropriate the program shall:
   1. Establish written procedures, which protect against the falsification and/or contamination of any urine sample.
   2. Document urinalysis results in the beneficiary's file.

12. **Assessment:**
   A. The provider shall ensure a counselor or LPHA completes a personal, medical, and substance use history for each beneficiary upon admission to treatment.
      1. Assessment for all beneficiaries shall include at a minimum:
         a. Drug/Alcohol use history
         b. Medical history
         c. Family history
         d. Psychiatric/psychological history
         e. Social/recreational history
         f. Financial status/history
         g. Educational history
         h. Employment history
         i. Criminal history
         j. Legal status
         k. Previous SUD treatment history
   B. The Medical Director or LPHA shall review each beneficiary's personal, medical, and substance use history if completed by a counselor within thirty (30) calendar days of each beneficiary's admission to treatment date.

13. **Beneficiary Record**
   A. In addition to the requirements of 22 CCR § 51476(a), the provider shall:
      1. Establish, maintain, and update as necessary, an individual beneficiary record for each beneficiary admitted to treatment and receiving services.
      2. Each beneficiary's individual beneficiary record shall include documentation of personal information.
      3. Documentation of personal information shall include all of the following:
      4. Information specifying the beneficiary's identifier (i.e., name, number).
      5. Date of beneficiary's birth, the beneficiary's sex, race and/or ethnic background, beneficiary's address and telephone number, and beneficiary's next of kin or emergency contact.
   B. Documentation of treatment episode information shall include documentation of all activities, services, sessions, and assessments, including, but not limited to all of the following:
      1. Intake and admission data including, a physical examination, if applicable.
      2. Treatment plans.
      3. Progress notes.
      4. Continuing services justifications.
      5. Laboratory test orders and results.
      6. Referrals.
      7. Discharge plan.

8. Discharge summary.
9. County authorizations for Residential Services.
10. Any other information relating to the treatment services rendered to the beneficiary.

14. **Diagnosis Requirements.**
    A. The Medical Director or LPHA shall evaluate each beneficiary's assessment and intake information if completed by a counselor through a face-to-face review or telehealth with the counselor to establish a beneficiary meets the medical necessity criteria in Section O. Beneficiary's Eligibility of this contract.
        1. The Medical Director or LPHA shall document separately from the treatment plan the basis for the diagnosis in the beneficiary's record within thirty (30) calendar days of each beneficiary's admission to treatment date.
            a. The basis for the diagnosis shall be a narrative summary based on DSM-5 criteria, demonstrating the Medical Director or LPHA evaluated each beneficiary's assessment and intake information, including their personal, medical, and substance use history.
            b. The Medical Director or LPHA shall type or legibly print their name, and sign and date the diagnosis narrative documentation. The signature shall be adjacent to the typed or legibly printed name.

15. **Physical Examination Requirements:**
    A. If a beneficiary had a physical examination within the twelve-month period prior to the beneficiary's admission to treatment date, the physician or registered nurse practitioner or physician's assistant (physician extenders) shall review documentation of the beneficiary's most recent physical examination within thirty (30) calendar days of the beneficiary's admission to treatment date.
        1. If a provider is unable to obtain documentation of a beneficiary's most recent physical examination, the provider shall describe the efforts made to obtain this documentation in the beneficiary's individual patient record.
    B. As an alternative to complying with paragraph (A) above or in addition to complying with paragraph (A) above, the physician or physician extender may perform a physical examination of the beneficiary within thirty (30) calendar days of the beneficiary's admission to treatment date.
    C. If the physician or a physician extender, has not reviewed the documentation of the beneficiary's physical examination as provided for in paragraph (A), or the provider does not perform a physical examination of the beneficiary as provided for in paragraph (B), then the LPHA or counselor shall include in the beneficiary's initial and updated treatment plans the goal of obtaining a physical examination, until this goal has been met and the physician has reviewed the physical examination results. The physician shall type or legibly print their name, sign, and date documentation to support they have reviewed the physical examination results. The signature shall be adjacent to the typed or legibly printed name.

16. **Treatment Plan:** For each beneficiary admitted to treatment services, the LPHA or counselor shall prepare an individualized written initial treatment plan, based upon the information obtained in the intake and assessment process.

The LPHA or counselor shall attempt to engage the beneficiary to meaningfully participate in the preparation of the initial treatment plan and updated treatment plans.

A. The initial treatment plan and updated treatment plans shall include all of the following:
    1. A statement of problems identified through the ASAM, other assessment tool(s) or intake documentation.
    2. Goals to be reached which address each problem.
    3. Action steps that will be taken by the provider and/or beneficiary to accomplish identified goals.
    4. Target dates for the accomplishment of action steps and goals.
    5. A description of the services, including the type of counseling, to be provided and the frequency thereof.
    6. The assignment of a primary therapist or counselor.
    7. The beneficiary's diagnosis as documented by the Medical Director or LPHA.
    8. If a beneficiary has not had a physical examination within the 12-month period prior to the beneficiary's admission to treatment date, a goal that the beneficiary have a physical examination.
    9. If documentation of a beneficiary's physical examination, which was performed during the prior 12 months, indicates a beneficiary has a significant medical illness, a goal that the beneficiary obtain appropriate treatment for the illness.
B. The provider shall ensure that the initial treatment plan meets all of the following requirements:
    1. The LPHA or counselor shall complete, type or legibly print their name, and sign and date the initial treatment plan within thirty (30) calendar days of the admission to treatment date. The signature shall be adjacent to the typed or legibly printed name.
    2. The beneficiary shall review, approve, type, or legibly print their name, sign and date the initial treatment plan, indicating whether the beneficiary participated in preparation of the plan, within thirty (30) calendar days of the admission to treatment date.
    3. If the beneficiary refuses to sign the treatment plan, the provider shall document the reason for refusal and the provider's strategy to engage the beneficiary to participate in treatment.
    4. If a counselor completes the initial treatment plan, the Medical Director or LPHA shall review the initial treatment plan to determine whether services are medically necessary and appropriate for the beneficiary.
C. If the Medical Director or LPHA determines the services in the initial treatment plan are medically necessary, the Medical Director or LPHA shall type or legibly print their name, and sign and date the treatment plan within fifteen (15) calendar days of signature by the counselor. The signature shall be adjacent to the typed or legibly printed name.
D. The provider shall ensure that the treatment plan is reviewed and updated as described below:
    1. The LPHA or counselor shall complete, type, or legibly print their name, sign and date the updated treatment plan no later than ninety (90) calendar days after signing the initial treatment plan, and no later than every ninety (90) calendar days thereafter, or when there is a change in treatment modality or significant event, whichever comes first. The signature shall be adjacent to the typed or legibly printed name. The

updated treatment plan shall be updated to reflect the current treatment needs of the beneficiary.

2. The beneficiary shall review, approve, type, or legibly print their name and, sign and date the updated treatment plan, indicating whether the beneficiary participated in preparation of the plan, within thirty (30) calendar days of signature by the LPHA or counselor.
3. If the beneficiary refuses to sign the updated treatment plan, the provider shall document the reason for refusal and the provider's strategy to engage the beneficiary to participate in treatment.
4. If a counselor completes the updated treatment plan, the Medical Director or LPHA shall review each updated treatment plan to determine whether continuing services are medically necessary and appropriate for the beneficiary.
5. If the Medical Director or LPHA determines the services in the updated treatment plan are medically necessary, they shall type or legibly print their name and, sign and date the updated treatment plan, within fifteen (15) calendar days of signature by the counselor. The signature shall be adjacent to the typed or legibly printed name.

17. **Sign-In Sheet:** Establish and maintain a sign-in sheet for every group counseling session, which shall include all of the following:
    A. The LPHA(s) and/or counselor(s) conducting the counseling session shall type or legibly print their name(s), sign, and date the sign-in sheet on the same day of the session. The signature(s) must be adjacent to the typed or legibly printed name(s). By signing the sign-in sheet, the LPHA(s) and/or counselor(s) attest that the sign-in sheet is accurate and complete.
    B. The date of the counseling session.
    C. The topic of the counseling session.
    D. The start and end time of the counseling session.
    E. A typed or legibly printed list of the participants' names and the signature of each participant that attended the counseling session. The participants shall sign the sign-in sheet at the start of or during the counseling session.

18. **Progress Notes:**
    A. Progress notes shall be legible and completed as follows:
        1. For outpatient services, Naltrexone treatment services, and recovery services, each individual and group session, the LPHA or counselor who conducted the counseling session or provided the service shall record a progress note for each beneficiary who participated in the counseling session or treatment service.
            a. The LPHA or counselor shall type or legibly print their name, and sign and date the progress note within seven (7) calendar days of the counseling session. The signature shall be adjacent to the typed or legibly printed name.
            b. Progress notes are individual narrative summaries and shall include all of the following:
                i. The topic of the session or purpose of the service.
                ii. A description of the beneficiary's progress on the treatment plan problems, goals, action steps, objectives, and/or referrals.
                iii. Information on the beneficiary's attendance, including the date, start and end times of each individual and group counseling session or treatment service.
                iv. Identify if services were provided in-person, by telephone, or by telehealth.

v. If services were provided in the community, identify the location and how the provider ensured confidentiality.

B. For intensive outpatient services and residential treatment services, the LPHA or counselor shall record, at a minimum, one progress note, per calendar week, for each beneficiary participating in structured activities including counseling sessions or other treatment services.
   1. The LPHA or counselor shall type or legibly print their name, and sign and date progress notes within the following calendar week. The signature shall be adjacent to the typed or legibly printed name.
   2. Progress notes are individual narrative summaries and shall include all of the following:
      a. A description of the beneficiary's progress on the treatment plan, problems, goals, action steps, objectives, and/or referrals.
      b. A record of the beneficiary's attendance at each counseling session including the date, start and end times and topic of the counseling session.
      c. Identify if services were provided in-person, by telephone, or by telehealth.
      d. If services were provided in the community, identify the location and how the provider ensured confidentiality.

C. For each beneficiary provided case management services, the LPHA or counselor who provided the treatment service shall record a progress note.
   1. The LPHA or counselor shall type or legibly print their name, and sign and date the progress note within seven (7) calendar days of the case management service. The signature shall be adjacent to the typed or legibly printed name.
   2. Progress notes shall include all of the following:
      a. Beneficiary’s name.
      b. The purpose of the service.
      c. A description of how the service relates to the beneficiary's treatment plan problems, goals, action steps, objectives, and/or referrals.
      d. Date, start and end times of each service.
      e. Identify if services were provided in-person, by telephone, or by telehealth.
      f. If services were provided in the community, identify the location and how the provider ensured confidentiality.

D. For physician consultation services, additional medication assisted treatment, the Medical Director or LPHA working within their scope of practice who provided the treatment service shall record a progress note and keep in the beneficiary’s file.
   1. The Medical Director or LPHA shall type or legibly print their name, and sign and date the progress note within seven (7) calendar days of the service. The signature shall be adjacent to the typed or legibly printed name.
   2. Progress notes shall include all of the following:
      a. Beneficiary’s name.
      b. The purpose of the service.
      c. Date, start and end times of each service.
      d. Identify if services were provided face-to-face, by telephone or by telehealth.

19. **Continuing Services:**
    A. Continuing services shall be justified as shown below:
        1. For outpatient services, intensive outpatient services, Naltrexone treatment, and case management:
            a. For each beneficiary, no sooner than five months and no later than six months after the beneficiary's admission to treatment date or the date of completion of the most recent justification for continuing services, the LPHA or counselor shall review the beneficiary's progress and eligibility to continue to receive treatment services, and recommend whether the beneficiary should or should not continue to receive treatment services at the same level of care.
            b. For each beneficiary, no sooner than five months and no later than six months after the beneficiary's admission to treatment date or the date of completion of the most recent justification for continuing services, the Medical Director or LPHA shall determine medical necessity for continued services for the beneficiary. The determination of medical necessity shall be documented by the Medical Director or LPHA in the beneficiary's individual patient record and shall include documentation that all of the following have been considered:
                i. The beneficiary's personal, medical and substance use history.
                ii. Documentation of the beneficiary's most recent physical examination.
                iii. The beneficiary's progress notes and treatment plan goals.
                iv. The LPHA's or counselor's recommendation pursuant to Paragraph (i) above.
                v. The beneficiary's prognosis.
                vi. The Medical Director or LPHA shall type or legibly print their name, and sign and date the continuing services information when completed. The signature shall be adjacent to the typed or legibly printed name.
        2. If the Medical Director or LPHA determines that continuing treatment services for the beneficiary is not medically necessary, the provider shall discharge the beneficiary from the current LOC and transfer to the appropriate services.
    B. Residential services length of stay shall be in accordance with County procedures for request of authorized residential services and the Intergovernmental Agreement 18-95146, or as may be amended.

20. **Discharge:**
    A. Discharge of a beneficiary from treatment may occur on a voluntary or involuntary basis. For outpatient services, intensive outpatient services and residential services, in addition to the requirements of this subsection, an involuntary discharge is subject to the requirements set forth in Health and Human Services Agency Policy N-SUDS-003 DMC-ODS Grievances, Appeals & Fair Hearing, which constitutes part of this Agreement, available at https://www.edcgov.us/Government/hhsa/Pages/hhsa_contractor_resources.aspx
    B. An LPHA or counselor shall complete a discharge plan for each beneficiary, except for a beneficiary with whom the provider loses contact.
        1. The discharge plan shall include, but not be limited to, all of the following:
            a. A description of each of the beneficiary's relapse triggers.
            b. A plan to assist the beneficiary to avoid relapse when confronted with each trigger.
            c. A support plan.

2. The discharge plan shall be prepared within thirty (30) calendar days prior to the scheduled date of the last face-to-face treatment with the beneficiary.
    a. If a beneficiary is transferred to a higher or lower level of care based on ASAM criteria within the same DMC certified program, they are not required to be discharged unless there has been more than a thirty (30) calendar day lapse in treatment services.
3. During the LPHA's or counselor's last face-to-face treatment with the beneficiary, the LPHA or counselor and the beneficiary shall type or legibly print their names, sign and date the discharge plan. The signatures shall be adjacent to the typed or legibly printed name. A copy of the discharge plan shall be provided to the beneficiary and documented in the beneficiary record.

C. The LPHA or counselor shall complete a discharge summary, for any beneficiary with whom the provider lost contact, in accordance with all of the following requirements:
1. The LPHA or counselor shall complete the discharge summary within thirty (30) calendar days of the date of the last face-to-face treatment contact with the beneficiary.
2. The discharge summary shall include all of the following:
    a. The duration of the beneficiary's treatment as determined by the dates of admission to and discharge from treatment.
    b. The reason for discharge.
    c. A narrative summary of the treatment episode.
    d. The beneficiary's prognosis.

21. **Certifications:** Any counselor or registrant providing intake, assessment of need for services, treatment or recovery planning, individual or group counseling to participants, patients, or residents in a DHCS licensed or certified program is required to be certified as defined in Title 9, Division 4, Chapter 8.

22. **Cultural Competency:**
A. Providers are responsible to provide culturally competent services. Providers shall ensure that their policies, procedures, and practices are consistent with the principles outlined and are embedded in the organizational structure, as well as being upheld in day-to-day operations. Translation services shall be available for beneficiaries, as needed.
B. To ensure equal access to quality care by diverse populations, each service provider receiving funds from this Agreement shall adopt the federal Office of Minority Health Culturally and Linguistically Appropriate Service (CLAS) national standards (Document 3V) and comply with 42 CFR 438.206(c)(2).
C. Provider shall ensure that the Client's primary spoken language and self-identified race and ethnicity are included in the CalOMS AVATAR system, the Provider's management information system, as well as any Client records used by provider staff.

23. **Evidence Based Practices (EBPs):** Providers will implement at least two of the following EBPs based on the timeline established in the county implementation plan. The two EBPs are per provider per service modality. The County will ensure the providers have implemented EBPs. The state will monitor the implementation and regular training of EBPs to staff during reviews. The required EBPs include:

A. Motivational Interviewing: A beneficiary-centered, empathic, but directive counseling strategy designed to explore and reduce a person's ambivalence toward treatment. This approach frequently includes other problem solving or solution-focused strategies that build on beneficiaries' past successes.
B. Cognitive-Behavioral Therapy: Based on the theory that most emotional and behavioral reactions are learned and that new ways of reacting and behaving can be learned.
C. Relapse Prevention: A behavioral self-control program that teaches individuals with substance addiction how to anticipate and cope with the potential for relapse. Relapse prevention can be used as a stand-alone substance use treatment program or as an aftercare program to sustain gains achieved during initial substance use treatment.
D. Trauma-Informed Treatment: Services shall take into account an understanding of trauma, and place priority on trauma survivors' safety, choice, and control.
E. Psycho-Education: Psycho-educational groups are designed to educate beneficiaries about substance abuse, and related behaviors and consequences. Psycho-educational groups provide information designed to have a direct application to beneficiaries' lives, to instill self- awareness, suggest options for growth and change, identify community resources that can assist beneficiaries in recovery, develop an understanding of the process of recovery, and prompt people using substances to take action on their own behalf.

24. **Program Integrity:**
A. Service Verification. To assist DHCS in meeting its obligation under 42 CFR 455.1(a)(2), the Provider shall establish a mechanism to verify whether services were actually furnished to beneficiaries. Provider will participate in service verification activities as required by this agreement. Provider shall utilize the following documents, all of which constitute part of this Agreement, available at https://www.edcgov.us/Government/hhsa/Pages/hhsa_contractor_resources.aspx
    a. DMC-ODS Service Verification Process
    b. DMC-ODS Service Verification Card Template
    c. DMC-ODS Service Verification Monthly Report Form
A. Provider shall adhere to the DMC-ODS Compliance Plan which constitutes part of this Agreement, available at https://www.edcgov.us/Government/hhsa/Pages/hhsa_contractor_resources.aspx
B. Requirements of a Compliance Program are set forth in 42 Code of Federal Regulations Sections 455.1 and 438.608. Further requirements for Program Integrity, which includes the Compliance Program, are established pursuant to the DMC-ODS Intergovernmental Agreement between the State of California Department of Health Care Services (DHCS) and El Dorado County HHSA, as well as through Information Notices issued by DHCS.
C. The requirements of the Compliance Program apply to all individuals who provide services, including billing or coding functions, in support the DMC-ODS operated by or through the County, including employees, volunteers, interns, and others working on behalf of the County in the provision of DMC-ODS Services. These individuals are generally referred to within this document as the "County workforce" or "County workforce members". In addition, the law specifies contractors that furnish, or authorize the furnishing of, Medi-Cal services, perform billing or coding functions, or are involved in the monitoring of services provided by the County, are covered under DMC-ODS Compliance Program. This includes contracted providers, contracted psychiatrists, and other network and organizational providers.

D. Suspected Medi-Cal fraud, waste, or abuse must be reported to: DHCS Medi-Cal Fraud: (800) 822-6222 or Fraud@dhcs.ca.gov

25. **Training:** Provider shall ensure that, at minimum, providers and staff conducting assessments are required to complete the two e-Training modules entitled "American Society of Additive Medicine (ASAM) Multidimensional Assessment" and "From Assessment to Service Planning and Level of Care." A third module entitled, "Introduction to The ASAM Criteria" is recommended for all provider staff providing services under this Agreement.

    The Provider shall ensure that all residential service providers meet the established ASAM criteria for each level of residential care they provide and receive an ASAM Designation prior to providing DMC-ODS services.

26. **Medication Assisted Treatment (MAT):** Provider will have procedures for linkage/integration for beneficiaries requiring MAT. Provider will regularly communicate with physicians of beneficiaries who are prescribed these medications unless the beneficiary refuses to consent to sign a 42 CFR part 2 compliant Release of Information for this purpose.

27. **Drug and Alcohol Treatment Access Report (DATAR):**
    A. All treatment providers shall be enrolled in DATAR.
    B. County shall be responsible for ensuring that treatment services and all treatment providers submit a monthly DATAR report in an electronic copy format as provided by California Department of Health Care Services (DHCS) and according to the DATAR Web Manual, which constitutes part of this Agreement, available at https://www.edcgov.us/Government/hhsa/Pages/hhsa_contractor_resources.aspx
    C. Reports shall be submitted by the 10th of the month following the report activity month.

28. **California Outcomes Measurement Systems (CalOMS):** Provider shall enter treatment admissions and discharge information into a specific database as directed by County and shall, on a monthly basis, submit same to HHSA Alcohol and Drug Program designee for submission to the State CalOMS database.

ARTICLE II – Term

This Agreement shall become effective upon final execution by both parties hereto and shall continue through December 31, 2020.

ARTICLE III – Funding Categories

A. AB 109 Treatment Services: ***Written authorization required***. Funding for services provided herein is provided by the 2011 El Dorado Public Safety Realignment Implementation Plan, and is subject to all laws and regulations promulgated under California Assembly Bill (AB) 109, AB 116, AB 117, ABXI 16 and ABXI 17, Statutes of 2011. El Dorado County DMC-ODS eligible beneficiaries who are also identified by County as eligible for AB 109 Treatment Services shall use their DMC-ODS benefits as their primary source of funding. AB109 treatment services funding will be used for beneficiary services that are not covered by DMC-ODS.

B. State General Fund and 2011 Realignment DMC-ODS: DMC-ODS is a treatment program as defined in Intergovernmental Agreement 18-95146, or as may be amended. Effective July 1, 2011, Local Realignment Revenues are used to fund DMC services to DMC beneficiaries, including Minor Consent Services. As of June 1, 2019, revenues are used to fund DMC-ODS services to DMC-ODS El Dorado County beneficiaries, including minor consent services.
    1. Federal Financial Participation (FFP) or Federal match on DMC-ODS: This funding is the Federal share of the DMC Program. The match, which varies by year, is usually at or near fifty percent (50%).
    2. DMC Eligibility Accepted as Payment in Full: Except where a share of cost, as defined in Intergovernmental Agreement 18-95146, or as may be amended, is applicable, providers shall accept proof of eligibility for DMC as payment in full for treatment services rendered. Providers shall not charge fees to beneficiaries for access to DMC substance abuse services or for admission to a DMC treatment slot.

C. Substance Abuse Prevention and Treatment Block Grant (SABG): ***Written authorization required***. Services under the Alcohol and Other Drug Counseling and Treatment Services category that are not funded by DMC may be funded by the Federal Block Grant – Substance Abuse Prevention and Treatment Block Grant (SABG): These are Federal funds which are to be used for specific services as follows:
    1. SABG Discretionary: These are Federal block grant funds, which are to be used in a discretionary manner for substance abuse treatment, prevention, and recovery services.
    2. SABG Federal Block Grant Perinatal Set Aside: These funds are for substance abuse services designated for pregnant/postpartum women.
    3. SABG Federal Block Grant Adolescent and Youth Treatment Programs: These funds are for substance abuse services to youth age 12 through 17 years (inclusive), as described in the Alcohol and Drug Program Youth Treatment Guidelines (2002).

For services provided under SABG, Provider shall ensure that Federal Block Grant funds are the "payment of last resort" for Alcohol and Other Drug Treatment Services subsidized under this Agreement. For that reason, Provider shall comply with the following guidelines with regard to charges for services, including the establishment of a sliding scale fee schedule. The sole purpose of the sliding scale is for use in billing clients for Alcohol and Other Drug Counseling Treatment Services.

A. Client Fees: Provider may charge a fee to clients for whom services are provided pursuant to this Agreement, assessing ability to pay based on individual expenses in relation to income, assets, estates, and responsible relatives. Client fees shall be based upon the person's ability to pay for services, but shall not exceed the actual cost of service provided. No person shall be denied services because of inability to pay. Determination of fees shall be established in accordance with a sliding fee schedule developed by Provider approved by the Contract Administrator, and **attached hereto as Exhibit 12.**

B. Client Financial Assessment: Provider shall certify all clients whose alcohol and drug treatment services are subsidized under this Agreement as unable to pay the amount charged to this Agreement. The certification of each client who is unable to pay shall be documented in writing on a Client Financial Assessment Form, which is developed by Provider and approved by Contract Administrator. This completed document shall be maintained by the Provider in the client's file.

In addition, Provider must demonstrate that Provider cannot collect at the "County Standardized Rate" from an insurance carrier or other benefit program, including but not limited to (1) the Social Security Act, including Title 19 CCR and Title 22 CCR programs, (2) any State compensation program, and (3) any other public assistance program for medical expenses, any grant program, or any other benefit program.

ARTICLE IV – Compensation for Services

For services provided herein, including any deliverables that may be identified herein, County agrees to pay Provider upon the satisfactory completion and County's acceptance of work, monthly in arrears and within forty-five (45) days following the County's receipt and approval of itemized invoice(s) identifying services rendered.

Rates				
Service Type	**Units of service**	**Rate per unit of service**	**Rate per minute (Billing Rate)**	
Individual Counseling – Outpatient Treatment Level 1.0	Per 15 Minutes	$64.74	$4.32	
Group Counseling – Outpatient Treatment Level 1.0	Per 15 Minutes	$64.74	$4.32	
Individual Counseling - Intensive Outpatient Level 2.1	Per 15 Minutes	$30.00	$2.00	
Group Counseling – Intensive Outpatient Level 2.1	Per 15 Minutes	$30.00	$2.00	
Patient Education – Intensive Outpatient Level 2.1	Per 15 Minutes	$30.00	$2.00	
Case Management	Per 15 Minutes	$30.00	$2.00	
Residential Level 3.1 (Perinatal and Non-Peri)	Per Bed Day			$91.05
Residential Level 3.1 Room & Board (Perinatal and Non-Peri)	Per Bed Day			$11.96
Recovery Residences	Per Day			$22.19

"Unit of Service" means a contact on a calendar day for outpatient drug free, intensive outpatient treatment, and residential treatment services.

DMC-ODS claims may be submitted with either minutes or fractional units of service in accordance with the DHCS DMC Provider Billing Manual.

Substance Abuse Testing	**Rate**
Urine sample 8 panel sent to lab (includes alcohol up to 24 hrs.)	$45.00 Per Test
Urine sample instant test only (10 Panel)	$45.00 Per Test
Urine sample instant test only (14 Panel)	$50.00 Per Test

Substance Abuse Testing	Rate
Urine sample instant test with 8 panel sent to lab	$55.00 Per Test
Urine sample 8 panel with adulteration test	$55.00 Per Test
Urine sample ETG 80 hrs (Alcohol) sent to lab	$55.00 Per Test
Urine sample 8 panel and ETG test sent to lab	$25.00 - $50.00 Per Test*
Hair test sent to lab	$35.00 Per Test
Special Additional Tests (per add-on).	$15.00 Per Test
Hair Test.	$100.00 Per Test
Alcohol Breathalyzer Test	$45.00 Per Test
Instant Alcohol Mouth Swab	$45.00 Per Test
Instant 6 Panel Mouth Swab for Drugs	$35.00 Per Test
ETG Nail Test	$180.00 Per Test
5 Panel Nail Test	$130.00 Per Test
5 Panel / ETG Combo Nail Test	$250.00 Per Test
7 Panel Nail Test	$150.00 Per Test
7 Panel / ETG Combo Nail Test	$275.00 Per Test
9 Panel Nail Test	$170.00 Per Test
9 Panel / ETG Combo Nail Test	$300.00 Per Test
Client Progress Reports. Upon Program Coordinator's request and/or no later than thirty (30) days after the end of each second service month, Contractor shall provide the Program Coordinator, at no charge to the County, with a brief written progress report outlining the primary issues being addressed with each Client, their progress, and ongoing treatment goals.	No Charge

*Rate varies depending on requested add-on or confirmation test. Contact Progress House for exact pricing.

A. Invoices: For services provided herein, Provider shall submit invoices, along with written treatment authorization, if applicable, for services fifteen (15) days following the end of a "service month." For billing purposes, a "service month" shall be defined as a calendar month during which Provider provides services in accordance with **ARTICLE I, Responsibilities and Services, Section 3, Scope of Services**. For all satisfactory services provided herein, County agrees to pay Provider monthly in arrears and within forty-five (45) days following County receipt and approval of itemized invoice(s) detailing services rendered and the date(s) services were rendered. County may withhold or delay any payment if Provider fails to comply with any provision of this Agreement.

County shall not pay for any invoices for AB 109 treatment services, additional case management services, recovery residences services, residential, SABG, that have not been approved in writing by the Contract Administrator or designee, incomplete services, "no show" cancellations, telephone calls or for the preparation of progress reports.

Two-Step Process *(Drug Medi-Cal Services)*: Provider shall submit an Excel data file **and** paper invoice to County for payment.

Step 1: Provider shall submit an Excel data file with columns as identified below. To avoid federal and state HIPAA violations, County requires that Providers submit client's protected private health information (PHI) via the County's Secured File Transfer Protocol (SFTP) server, or by using a secured and encrypted email protocol in compliance with HIPPA security regulations. To gain access the County's SFTP server, please email: dmc-odsinvoices@edcgov.us.

The Excel data file shall include the following information:

1. First Name
2. Last Name
3. Client Address
4. Date of Birth
5. CIN #
6. Diagnosis
7. Admission Date
8. Date of Service
9. Practitioner Name
10. Units/Duration
11. Billed Amount

Step 2: County will perform a review and approval of the submitted Excel data file and notify Provider of services approved for billing. Upon approval by County, Provider shall submit a paper invoice, signed and dated by Provider's authorized representative, detailing services approved for billing.

Invoice Submittal/Remittance *(All Services)*: Paper invoices shall be submitted and remitted as follows, or as otherwise directed in writing by County. Invoices must include the following information:

1. County Issued Agreement Number
2. Provider Name & Address
3. Service Month
4. Invoice Total
5. Service Totals (Units & Cost total per service code)
6. Provider Contact Information
7. Written Treatment Authorization (if applicable)

Submit Invoices	**Remittance**
County of El Dorado Health and Human Services Agency 3057 Briw Road, Suite B Placerville, CA 95667 Attn: Fiscal Unit	Progress House, Inc. P.O. Box 1666 Placerville, CA 95667 Attn: Executive Director

A. Supplemental Invoices: For the purpose of this Agreement, supplemental invoices shall be defined as invoices submitted for additional services rendered during a month for which a

prior invoice has already been submitted to County. Supplemental Invoices shall follow the two-step process as defined herein above. Supplemental invoices should include the standard invoice format with description of services rendered and a detailed explanation why the invoice was not submitted in the approved timeframe. Written treatment authorization shall be submitted with invoices.

1. For the period July 1st through April 30th of this Agreement: Supplemental invoices for additional services as defined in **ARTICLE I, Responsibilities and Services, Section 3, Scope of Services** received after the second Monday in May, shall be neither accepted nor paid by the County.
2. For the period May 1st through June 30th of this Agreement: Any supplemental invoices for additional services as defined in **ARTICLE I, Responsibilities and Services, Section 3, Scope of Services** received after the second Monday in July shall be neither accepted nor paid by the County.

Denied Invoices: DMC payments shall be made in the amount of the Provider's total claim, minus the amount of denied services. County will submit to Provider the amount of denials received for the prior months' services, as identified on documents received from the State. Provider shall make adjustment for denials on Provider's next submitted invoice.

ARTICLE V – Maximum Obligation

The total obligation for services provided during the term of this Agreement as stated herein below:

AB 109: $23,750.00

SABG Discretionary Fund: $48,720.00

SABG Perinatal Fund: $48,000.00

Other (DMC w/ FFP, Realignment, State General Fund): $1,147,777.00

Total Maximum Contractual Obligation: $1,268,247.00, inclusive of all costs and expenses for the term of the Agreement.

ARTICLE VI – Federal Funding Notification

A. DUNS Number, and System for Award Management: As a government agency responsible for the administration of Federal funding, County has an obligation under Title 12, Subtitle A, Chapter 1 Part 180 of the Code of Federal Regulations to ensure those contractors receiving federal funds are not debarred or suspended. Therefore, Provider is required to obtain and maintain an active DUNS number, as well as an active registration in the System Award Management (SAM.gov). Noncompliance with these two requirements shall result in corrective action, up to and including termination pursuant to the provisions contained herein under **ARTICLE XVII, Default, Termination, and Cancellation, or ARTICLE XV, Fiscal Considerations.**

1. Business entities may register for a DUNS number at https://www.dnb.com/duns-number/get-a-duns.html

2. The Provider must register the DUNS number and maintain an "Active" status within the federal System for Award Management available online at https://www.sam.gov/SAM/
3. If County cannot access or verify "Active" status the Provider's DUNS information, which is related to this federal subaward on the Federal Funding Accountability and Transparency Act Subaward Reporting System (SAM.gov) due to errors in the Provider's data entry for its DUNS number, the Provider must immediately update the information as required.

B. Catalog of Federal Domestic Assistance: Pursuant to the Office of Management and Budget (OMB) Uniform Grants Guidance, all recipients and sub-recipients of federal funds must be provided the Catalog of Federal Domestic Assistance (CFDA) number at the time the contract is awarded. The following are CFDA numbers, award specific information, and program titles for programs administered by the County on behalf of California Department of Social Services that may apply to this contract:

<table>
<tr><td colspan="5">Federal Funding Subrecipient Information</td></tr>
<tr><td colspan="2">Provider:</td><td colspan="2">Progress House, Inc.</td><td>DUNS #: 161236500</td></tr>
<tr><td colspan="2">Award Term:</td><td colspan="2">Execution through 12/31/2020</td><td>EIN #: 94-2535820</td></tr>
<tr><td colspan="5">Total Federal Funds Obligated: Up to $1,268,247.00</td></tr>
<tr><td colspan="5"></td></tr>
<tr><td colspan="5">Federal Award Information</td></tr>
<tr><td>CFDA Number</td><td colspan="2">Federal Award ID Number (FAIN)</td><td>Federal Award Date / Amount</td><td>Program Title</td></tr>
<tr><td>93.778</td><td colspan="2"></td><td>06/01/2019</td><td>Drug Medi-Cal Organized Delivery System Services (DMC-ODS)</td></tr>
<tr><td>93.959</td><td colspan="2"></td><td>07/01/2017</td><td>Substance Abuse Prevention and Treatment Block Grant (SABG)</td></tr>
<tr><td>Project Description:</td><td colspan="4">Substance Use Disorder Treatment Services for referred clients by The County of El Dorado, Health and Human Services Agency.</td></tr>
<tr><td>Awarding Agency:</td><td colspan="4">California Department of Health Care Services</td></tr>
<tr><td>Pass-through Entity</td><td colspan="4">County of El Dorado, Health and Human Services Agency</td></tr>
<tr><td>Indirect Cost Rate or de minimus</td><td colspan="2">Indirect Cost Rate: _____</td><td colspan="2">De minimus ☒</td></tr>
<tr><td>Yes ☐</td><td>No ☒</td><td colspan="3">Award is for Research and development.</td></tr>
</table>

ARTICLE VII – Cost Report

A. Contractor shall submit monthly income, balance sheet, cash flow statements, and completed audits performed by external entities to County by the 20th of each month, covering the prior month, for the term of this Agreement.

B. Provider shall submit a mock State DMC Cost Report to HHSA on or before December 4, 2020, covering all expenditures for services provided herein.

C. Provider shall submit a State DMC Cost Report to HHSA on or before September 15 for each year of this Agreement, covering all expenditures for services provided herein.

D. Provider shall prepare the Cost Report in accordance with all federal, state, and County requirements and generally accepted accounting principles (GAAP). Provider shall allocate direct and indirect costs to, and between, programs, cost centers, services, and funding sources in accordance with such requirements and consistent with prudent business practice. Such costs and allocations shall be supported by source documentation maintained by Provider and available at any time to Contract Administrator upon reasonable notice.

E. Provider shall document that costs are reasonable and allowable, and directly or indirectly related to the services provided hereunder. The Cost Report shall be the final financial record of services rendered under this Agreement for subsequent audits, if any.

F. Initial Cost Report Settlement between Provider and County shall be based upon the actual and reimbursable costs for services hereunder. Provider shall not claim expenditures to County that are not reimbursable pursuant to applicable federal, state, and County laws, regulations, and requirements. Any payment made by County to Provider, which is subsequently determined to have been for a non-reimbursable expenditure or service, shall be repaid by Provider to County in cash within forty-five (45) days of submission of the Cost Report.

G. If the Cost Report shows the actual and reimbursable cost of services provided pursuant to this Agreement is lower than the aggregate of monthly payments to Provider, Provider shall remit 90 percent of the difference to County. Such reimbursement shall be made with the submission of the Cost Report on September 15th.

H. When the State reconciliation of costs occurs, if the State settlement shows that the aggregate of monthly payments to Provider for covered services provided under this agreement exceeds Provider's allowable cost, in accordance with Title 22 CCR Section 51516.1, Provider shall remit the difference to County. Provider shall pay County the difference within forty-five (45) days after the date of settlement or the completion of an Appeal Process through County, whichever comes first. The amount due to County will be inclusive of any amount initially paid to County with the submission of the Cost Report. Amount due to County for the Fiscal Year will be finalized upon the State settlement of the Cost Report. If the State settlement identifies payment due to Provider, for costs reported in accordance with the terms and conditions of the contract in which State funding was received, funding will be passed to Provider through County after finalization of the settlement with the State. In the event of a State cost report audit and/or program audit, both Local Realignment Revenue and Federal Medicaid portions of all Provider disallowances shall be reimbursed to County within forty-five (45) days of the final audit report or of completion of an appeal process following receipt of a final Audit Report or the completion of an Appeal Process through County, whichever comes first. Any amounts due County that remain unpaid by the forty-five (45) days will be paid through a 50 percent offset of current invoices, that are pending payment to Provider, until paid in full.

ARTICLE VIII – Record Retention

A. Provider shall retain beneficiary records for a minimum of 10 years, in accordance with 438.3(h), from the finalized cost settlement process with the Department. When an audit by the Federal Government or DHCS has been started before the expiration of the 10-year

period, the beneficiary records shall be maintained until completion of the audit and the final resolution of all issues.

B. Provider shall comply with, and include in any subcontract with providers, the mandate to keep and maintain records for each service rendered, to whom it was rendered, and the date of service, pursuant to Welfare and Institutions Code 14124.1 and 42 CFR 438.3(h) and 438.3(u).

C. County shall ensure that any Provider sites authorized shall keep a record of the beneficiaries/patients being treated at that location.

ARTICLE IX – Health Information Portability and Accountability Act (HIPAA) and Confidentiality (42 CFR Section 438.224):

A. If any of the work performed under this Agreement is subject to the HIPAA, Provider shall perform the work in compliance with all applicable provisions of HIPAA. By signing this Agreement, Provider agrees to the terms and conditions of the HIPAA Business Associate Agreement, **attached hereto as Exhibit 13**, and incorporated by reference herein.

B. For medical records and any other health and enrollment information that identifies a particular beneficiary, the Provider shall use and disclose such individually identifiable health information in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E and 42 CFR Part 2, to the extent that these requirements are applicable.

ARTICLE X – Taxes

Provider certifies that as of today's date, it is not in default on any unsecured property taxes or other taxes or fees owed by Provider to County. Provider agrees that it shall not default on any obligations to County during the term of this Agreement.

ARTICLE XI – Changes to Agreement

This Agreement may be amended by mutual consent of the parties hereto. Said amendments shall become effective only when in writing and fully executed by duly authorized officers of the parties hereto.

ARTICLE XII – Provider to County

It is understood that the services provided under this Agreement shall be prepared in and with cooperation from County and its staff. It is further agreed that in all matters pertaining to this Agreement, Provider shall act as Provider only to County and shall not act as Provider to any other individual or entity affected by this Agreement nor provide information in any manner to any party outside of this Agreement that would conflict with Providers responsibilities to County during term hereof.

ARTICLE XIII – Assignment and Delegation
Provider is engaged by County for its unique qualifications and skills as well as those of its personnel. Provider shall not subcontract, delegate or assign services to be provided, in whole or in part, to any other person or entity.

ARTICLE XIV – Independent Contractor/Liability
Provider is, and shall be at all times, deemed independent and shall be wholly responsible for the manner in which it performs services required by terms of this Agreement. Provider exclusively assumes responsibility for acts of its employees, associates, as they relate to services to be provided under this Agreement during the course and scope of their employment.

Provider shall be responsible for performing the work under this Agreement in a safe, professional, skillful, and workmanlike manner and shall be liable for its own negligence and negligent acts of its employees. County shall have no right of control over the manner in which work is to be done and shall, therefore, not be charged with responsibility of preventing risk to Provider or its employees.

ARTICLE XV – Fiscal Considerations
The parties to this Agreement recognize and acknowledge that County is a political subdivision of the State of California. As such, El Dorado County is subject to the provisions of Article XVI, Section 18 of the California Constitution and other similar fiscal and procurement laws and regulations and may not expend funds for products, equipment or services not budgeted in a given fiscal year. It is further understood that in the normal course of County business, County will adopt a proposed budget prior to a given fiscal year, but that the final adoption of a budget does not occur until after the beginning of the fiscal year.

Notwithstanding any other provision of this Agreement to the contrary, County shall give notice of cancellation of this Agreement in the event of adoption of a proposed budget that does not provide for funds for the services, products or equipment subject herein. Such notice shall become effective upon the adoption of a final budget which does not provide funding for this Agreement. Upon the effective date of such notice, this Agreement shall be automatically terminated and County released from any further liability hereunder.

In addition to the above, should the Board of Supervisors during the course of a given year for financial reasons reduce, or order a reduction, in the budget for any County department for which services were contracted to be performed, pursuant to this paragraph in the sole discretion of the County, this Agreement may be deemed to be canceled in its entirety subject to payment for services performed prior to cancellation.

ARTICLE XVI – Training for Provider
A. Monitoring Training: The County shall ensure that Provider receives training on the DMC-ODS requirements, at least annually.

ARTICLE XVII – Audits, Compliance, and Monitoring

A. Program Integrity Safeguards: Consistent with 42 CFR Section 438.66, the County shall monitor the Provider's compliance, as applicable, with 42 CFR Sections 438.604, 438.606, 438.608, 438.620, 438.230,438.808, 438.900 et seq

B. County is also required to monitor the Provider compliance pursuant to Agreement 18-95146, or as may be amended, Exhibit A, Attachment I, Article III.AA.

1. Provider shall provide a copy of any Audit to County within thirty (30) days of completion of said audit, consistent with 45 CFR Subpart F, as applicable.
2. Audits or monitoring by the County may be performed by way of annual Contract Monitoring Surveys. Provider receiving a Contract Monitoring Survey shall, within sixty (60) days of receipt, complete and return the survey along with all documentation, details, and supporting materials required by the survey or otherwise necessary for the County to verify compliance with the terms and conditions of the Agreement. Failure to return the survey within the specified time period may result in the withholding of payment from the Provider until such time as compliance with the terms of the Agreement can be verified. Verifying compliance may necessitate additional on-site reviews should information submitted by the Provider be deemed insufficient or inaccurate.

C. State Audits: Provider acknowledges that if total compensation under this agreement is greater than $10,000.00, this Agreement is subject to examination and audit by the California State Auditor for a period of three (3) years, or for any longer period required by law, after final payment under this Agreement, pursuant to California Government Code §8546.7. In order to facilitate these potential examinations and audits, Provider shall maintain, for a period of at least three (3) years, or for any longer period required by law, after final payment under the contract, all books, records and documentation necessary to demonstrate performance under the Agreement.

D. The State, CMS, the Office of the Inspector General, the Comptroller General, the County, and their designees may, at any time, inspect and audit any records or documents of the County, or its Providers, and may, at any time, inspect the premises, physical facilities, and equipment where Medicaid-related activities are conducted. The right to audit under this section exists for 10 years from the final date of the Agreement period or from the date of completion of any audit, whichever is later.

E. The State, CMS, the Health and Human Services (HHS) Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the Provider, that pertain to any aspect of services and activities performed, or determination of amounts payable under this Agreement at any time;

F. The Provider will make available, for purposes of an audit, evaluation, or inspection, its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems relating to its Medicaid beneficiaries;

G. The State, CMS, the HHS Inspector General, the Comptroller General, or their designees' right to audit the Provider will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.

H. If the State, CMS, or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, the State, CMS, or the HHS Inspector General may inspect, evaluate, and audit the Provider at any time.

I. Upon notification of an exception or finding of non-compliance, the Provider shall submit evidence of Corrective Action within thirty (30) days, or as otherwise specified in the notice of required corrective action provided by the County. Continued non-compliance beyond due date for submission of Corrective Action may lead to termination of this Agreement in accordance with ARTICLE XVII, Default, Termination, and Cancellation.

J. Failure by County to notify or require Corrective Action does not constitute acceptance of the practice of waiver of the County's right to enforce.

K. Provider shall be held accountable for audit exceptions taken by DHCS against the Provider and its subcontractors for any failure to comply with these requirements:

i. HSC, Division 10.5, commencing with Section 11760
ii. Title 9, Division 4, Chapter 8, commencing with Section 13000
iii. Government Code Section 16367.8
iv. Title 42, CFR, Sections 8.1 through 8.6
v. Title 21, CFR, Sections 1301.01 through 1301.93, Department of Justice, Controlled Substances
vi. State Administrative Manual (SAM), Chapter 7200 (General Outline of Procedures)

L. Provider shall be familiar with the above laws, regulations, and guidelines and shall ensure that its subcontractors are also familiar with such requirements.

ARTICLE XVIII – Default, Termination, and Cancellation:

A. Default: Upon the occurrence of any default of the provisions of this Agreement, a party shall give written notice of said default to the party in default (notice). If the party in default does not cure the default within ten (10) days of the date of notice (time to cure), then such party shall be in default. The time to cure may be extended at the discretion of the party giving notice. Any extension of time to cure must be in writing, prepared by the party in default for signature by the party giving notice, and must specify the reason(s) for the extension and the date on which the extension of time to cure expires.

Notice given under this section shall specify the alleged default and the applicable Agreement provision and shall demand that the party in default perform the provisions of this Agreement within the applicable period of time. No such notice shall be deemed a termination of this Agreement unless the party giving notice so elects in this notice, or the party giving notice so elects in a subsequent written notice after the time to cure has expired. In the event of termination for default, County reserves the right to take over and complete the work by contract or by any other means.

Nullification of Agreement: The parties hereto agree that failure of the Provider, to comply with the terms and conditions of this Agreement and Welfare and Institutions Code Section 14124.24, available at https://leginfo.legislature.ca.gov/faces/codes_displayText.xhtml?lawCode=WIC&division=9.&title=&part=3.&chapter=7.&article=1, shall be deemed a breach that results in the termination of this Agreement for cause.

B. Bankruptcy: This Agreement, at the option of the County, shall be terminable in the case of bankruptcy, voluntary or involuntary, or insolvency of Provider.

C. Ceasing Performance: County may terminate this Agreement in the event Provider ceases to operate as a business, or otherwise becomes unable to substantially perform any term or condition of this Agreement.

D. Termination or Cancellation without Cause: County may terminate this Agreement in whole or in part upon seven (7) calendar day written notice by County without cause. If such prior termination is effected, County will pay for satisfactory services rendered prior to the effective dates as set forth in the Notice of Termination provided to Provider, and for such other services, which County may agree to in writing as necessary for contract resolution. In no event, however, shall County be obligated to pay more than the total amount of the contract. Upon receipt of a Notice of Termination, Provider shall promptly discontinue all services affected, as of the effective date of termination set forth in such Notice of Termination, unless the notice directs otherwise.

ARTICLE XIX – Notice to Parties

All notices to be given by the parties hereto shall be in writing and served by depositing same in the United States Post Office, postage prepaid and return receipt requested. Notices to County shall be addressed as follows:

COUNTY OF EL DORADO
Health and Human Services Agency
3057 Briw Road, Suite B
Placerville, CA 95667
ATTN: Contracts Unit

or to such other location as the County directs.

with a carbon copy to

COUNTY OF EL DORADO
Chief Administrative Office
Procurement and Contracts Division
2850 Fairland Court, Bldg. C, 2nd Fl.
Placerville, CA 95667
ATTN: Purchasing Agent

Notices to Provider shall be addressed as follows:

PROGRESS HOUSE, INC.
P.O. Box 1666
Placerville, CA 95667
ATTN: Executive Director

or to such other location as the Provider directs.

ARTICLE XX – Change of Address

In the event of a change in address for Provider's principal place of business, Provider's Agent for Service of Process, or Notices to Provider, Provider shall notify County in writing pursuant to the provisions contained in this Agreement under **ARTICLE XIX, Notice to Parties**. Said notice shall become part of this Agreement upon acknowledgment in writing by the County Contract Administrator, and no further amendment of the Agreement shall be necessary provided that such change of address does not conflict with any other provisions of this Agreement.

ARTICLE XXI – Indemnity

The Provider shall defend, indemnify, and hold the County harmless against and from any and all claims, suits, losses, damages and liability for damages of every name, kind and description, including attorney's fees and costs incurred, brought for, or on account of, injuries to or death of any person, including but not limited to workers, County employees, and the public, or damage to property, or any economic or consequential losses, which are claimed to or in any way arise out of or are connected with the Provider's services, operations, or performance hereunder, regardless of the existence or degree of fault or negligence on the part of the County, the Provider, and employee(s) of any of these, except for the sole, or active negligence of the County, its officers and employees, or as expressly prescribed by statute. This duty of Provider to indemnify and save County harmless includes the duties to defend set forth in California Civil Code Section 2778.

ARTICLE XXII – Insurance

Provider shall provide proof of a policy of insurance satisfactory to the County of El Dorado Risk Manager and documentation evidencing that Provider maintains insurance that meets the following requirements:

A. Full Worker's Compensation and Employer's Liability Insurance covering all employees of Provider as required by law in the State of California.

B. Commercial General Liability Insurance of not less than $1,000,000.00 combined single limit per occurrence for bodily injury and property damage and a $2,000,000.00 aggregate limit.

C. Automobile Liability Insurance of not less than $1,000,000.00 is required in the event motor vehicles are used by the Provider in the performance of the Agreement.

D. In the event Provider is a licensed professional or professional consultant, and is performing professional services under this Agreement, professional liability is required with a limit of liability of not less than $1,000,000.00 per occurrence.

E. Provider shall furnish a certificate of insurance satisfactory to the County of El Dorado Risk Manager as evidence that the insurance required above is being maintained.

F. The insurance will be issued by an insurance company acceptable to Risk Management, or be provided through partial or total self-insurance likewise acceptable to Risk Management.

G. Provider agrees that the insurance required above shall be in effect at all times during the term of this Agreement. In the event said insurance coverage expires at any time or times during the term of this Agreement, Provider agrees to provide at least thirty (30) days prior to said expiration date, a new certificate of insurance evidencing insurance coverage as provided for herein for not less than the remainder of term of the Agreement, or for a

period of not less than one (1) year. New certificates of insurance are subject to the approval of Risk Management and Provider agrees that no work or services shall be performed prior to the giving of such approval. In the event the Provider fails to keep in effect at all times insurance coverage as herein provided, County may, in addition to any other remedies it may have, terminate this Agreement upon the occurrence of such event.

H. The certificate of insurance must include the following provisions stating that:
   1. The insurer will not cancel the insured's coverage without prior written notice to County, and;
   2. The County of El Dorado, its officers, officials, employees and volunteers are included as additional insured on an additional insured endorsement, but only insofar as the operations under this Agreement are concerned. This provision shall apply to the general liability policy.

I. The Provider's insurance coverage shall be primary insurance as respects the County, its officers, officials, employees and volunteers. Any insurance or self-insurance maintained by the County, its officers, officials, employees or volunteers shall be in excess of the Provider's insurance and shall not contribute with it.

J. Any deductibles or self-insured retentions must be declared to and approved by the County, either: the insurer shall reduce or eliminate such deductibles or self-insured retentions as respects the County, its officers, officials, employees and volunteers; or the Provider shall procure a bond guaranteeing payment of losses and related investigations, claim administration and defense expenses.

K. Any failure to comply with the reporting provisions of the policies shall not affect coverage provided to the County, its officers, officials, employees or volunteers.

L. The insurance companies shall have no recourse against the County of El Dorado, its officers and employees or any of them for payment of any premiums or assessments under any policy issued by any insurance company.

M. Provider's obligations shall not be limited by the foregoing insurance requirements and shall survive expiration of this Agreement.

N. In the event Provider cannot provide an occurrence policy, Provider shall provide insurance covering claims made as a result of performance of this Agreement for not less than three (3) years following completion of performance of this Agreement.

O. Certificate of insurance shall meet such additional standards as may be determined by the contracting County Department either independently or in consultation with Risk Management, as essential for protection of the County.

ARTICLE XXIII – Interest of Public Official

No official or employee of County who exercises any functions or responsibilities in review or approval of services to be provided by Provider under this Agreement shall participate in or attempt to influence any decision relating to this Agreement which affects personal interest or interest of any corporation, partnership, or association in which he/she is directly or indirectly interested; nor shall any such official or employee of County have any interest, direct or indirect, in this Agreement or the proceeds thereof.

ARTICLE XXIV – Interest of Provider

Provider covenants that Provider presently has no personal interest or financial interest, and shall not acquire same in any manner or degree in either: 1) any other contract connected with or directly affected by the services to be performed by this Agreement; or, 2) any other entities connected with or directly affected by the services to be performed by this Agreement. Provider further covenants that in the performance of this Agreement no person having any such interest shall be employed by Provider.

ARTICLE XXV – Conflict of Interest

The parties to this Agreement have read and are aware of the provisions of Government Code Section 1090 et seq. and Section 87100 relating to conflict of interest of public officers and employees. Provider attests that it has no current business or financial relationship with any County employee(s) that would constitute a conflict of interest with provision of services under this contract and will not enter into any such business or financial relationship with any such employee(s) during the term of this Agreement. County represents that it is unaware of any financial or economic interest of any public officer or employee of Provider relating to this Agreement. It is further understood and agreed that if such a financial interest does exist at the inception of this Agreement either party may immediately terminate this Agreement by giving written notice as detailed in **ARTICLE XVIII, Default, Termination and Cancellation.**

ARTICLE XXVI – Nondiscrimination:

A. By signing this Agreement, Provider certifies that under the laws of the United States and the State of California, incorporated into this Agreement by reference and made a part hereof as if set forth in full, Provider shall not unlawfully discriminate against any person.

B. County may require Provider's services on projects involving funding from various state and/or federal agencies, and as a consequence, Provider shall comply with all applicable nondiscrimination statutes and regulations during the performance of this Agreement including but not limited to the following: Provider and its employees and representatives shall not unlawfully discriminate against any employee or applicant for employment because of race, religion, color, national origin, ancestry, physical handicap, medical condition, marital status, age, or sex; Provider shall, unless exempt, comply with the applicable provisions of the Fair Employment and Housing Act (Government Code, Sections 12900 et seq.) and applicable regulations promulgated thereunder (California Code of Regulations, Title 2, Sections 7285.0 et seq.); the applicable regulations of the Fair Employment and Housing Commission implementing Government Code, Section 12990, set forth in Chapter 5 of Division 4 of Title 2 of the California Code of Regulations incorporated into this Agreement by reference and made a part hereof as if set forth in full; and Title VI of the Civil Rights Act of 1964, as amended. Provider and its employees and representatives shall give written notice of their obligations under this clause as required by law.

C. Where applicable, Provider shall include these nondiscrimination and compliance provisions in any of its agreements that affect or are related to the services performed herein.

D. Provider's signature shall provide any certifications necessary under the federal laws, the laws of the State of California, including but not limited to Government Code Section 12990 and Title 2, California Code of Regulations, Section 8103.

E. By signing this Agreement, Provider certifies that under the laws of the United States and the State of California, incorporated into this Agreement by reference and made a part hereof as if set forth in full, Provider shall not unlawfully discriminate against any person.

ARTICLE XXVII – California Residency (Form 590)

If Provider is a California resident, Providers must file a State of California Form 590, certifying its California residency or, in the case of a corporation, certifying that it has a permanent place of business in California. The Provider will be required to submit a Form 590 prior to execution of an Agreement or County shall withhold seven (7) percent of each payment made to the Provider during term of the Agreement. This requirement applies to any agreement/contract exceeding $1,500.00.

ARTICLE XXVIII – Nonresident Withholding

If Provider is not a California resident, Provider shall provide documentation that the State of California has granted a withholding exemption or authorized reduced withholding prior to execution of this Agreement or County shall withhold seven (7%) percent of each payment made to the Provider during term of the Agreement as required by law. This requirement applies to any agreement/contract exceeding $1,500.00. Provider shall indemnify and hold the County harmless for any action taken by the California Franchise Tax Board.

ARTICLE XXIX – Taxpayer Identification Number (Form W-9)

All independent Providers or corporations providing services to the County must file a Department of the Treasury Internal Revenue Service Form W-9, certifying their Taxpayer Identification Number.

ARTICLE XXX – County Business License

It is unlawful for any person to furnish supplies or services, or transact any kind of business in the unincorporated territory of El Dorado County without possessing a County business license unless exempt under County Code Section 5.08.070.

ARTICLE XXXI – Licenses

Provider hereby represents and warrants that Provider and any of its employed under this Agreement has all the applicable licenses, permits, and certifications that are legally required for Provider and its to practice its profession or provide the services or work contemplated under this Agreement in the State of California. Provider shall obtain or maintain said applicable licenses, permits, or certificates in good standing throughout the term of this Agreement.

ARTICLE XXXII – Administrator
The County Officer or employee with responsibility for administering this Agreement is Salina Drennan, Substance Use Disorder Services Program Manager, or successor.

ARTICLE XXXIII – Authorized Signatures
The parties to this Agreement represent that the undersigned individuals executing this Agreement on their respective behalf are fully authorized to do so by law or other appropriate instrument and to bind upon said parties to the obligations set forth herein.

ARTICLE XXXIV – Partial Liability
If any provision of this Agreement is held by a court of competent jurisdiction to be invalid, void or unenforceable, the remaining provisions will continue in full force and effect without being impaired or invalidated in any way.

ARTICLE XXXV – Venue
Any dispute resolution action arising out of this Agreement, including, but not limited to, litigation, mediation, or arbitration, shall be brought in El Dorado County, California, and shall be resolved in accordance with the laws of the State of California.

ARTICLE XXXVI – No Third Party Beneficiaries
Nothing in this Agreement is intended, nor will be deemed, to confer rights or remedies upon any person or legal entity not a party to this agreement.

ARTICLE XXXVII – Additional Terms and Conditions
Provider shall comply with all applicable provisions of the Agreement #18-95416 between the County and State of California Department of Health Care Services, which constitute part of this Agreement, available at https://www.edcgov.us/Government/hhsa/Pages/hhsa_contractor_resources.aspx. Noncompliance with the aforementioned agreement and its terms and conditions may result in termination of this Agreement by giving written notice as detailed in **ARTICLE XVIII, Default, Termination, and Cancellation.**

Additional terms and conditions include, but are not limited to the following:

A. Licenses: Provider shall comply with the following:
   1. Title 21, CFR Part 1300, et seq., Title 42, CFR, Part 8
   2. Title 22, Sections 51490.1(a)
   3. Agreement 18-95146, or as may be amended, Exhibit A, Attachment I, Article III. – PP "Requirements for Services."
   4. Title 9, Division 4, Chapter 4, Subchapter 1, Sections 10000, et seq
   5. Title 22, Division 3, Chapter 3, sections 51000 et. seq

B. Hatch Act: Provider agrees to comply with the provisions of the Hatch Act (Title 5 USC, Sections 1501-1508), which limit the political activities of employees whose principal employment activities are funded in whole or in part with federal funds.

C. No Unlawful Use or Unlawful Use Messages Regarding Drugs: Provider agrees that information produced through these funds, and which pertains to drug and alcohol related programs, shall contain a clearly written statement that there shall be no unlawful use of drugs or alcohol associated with the program. Additionally, no aspect of a drug or alcohol related program shall include any message on the responsible use, if the use is unlawful, of drugs or alcohol (HSC Section 11999-11999.3). By signing this Agreement, Provider agrees that it shall enforce, these requirements.

D. Drug-Free Workplace: Provider agrees to maintain a drug-free workplace and remain in compliance with the Federal Drug-Free Workplace Act of 1988 (41 U.S.C. Chapter 10) and the California Drug-Free Workplace Act of 1990 (Government Code Section 8350 et seq.) and any subsequent amendments to either Act thereto. A "drug free workplace" means the site(s) for the performance of work done by Provider at which Provider and employees of the Provider are prohibited from engaging in the unlawful manufacture, distribution, dispensing, possession, or use of any controlled substance. A list of controlled substances can be found in Schedules I through V of Section 202 of the Controlled Substances Act (21 U.S.C. 812) and as further defined in Regulation 21 Code of Federal Regulations (CFR) 1308.11 – 1308.15. Provider will comply with the requirements of the Drug-Free Workplace Act of 1990 and will provide a drug-free workplace by taking the following actions:
    1. Publish a statement notifying employees that unlawful manufacture, distribution, dispensation, possession or use of a controlled substance is prohibited and specifying actions to be taken against employees for violations.
    2. Establish a Drug-Free Awareness Program to inform employees about:
        a. The dangers of drug abuse in the workplace;
        b. The person's or organization's policy of maintaining a drug-free workplace;
        c. Any available counseling, rehabilitation and employee assistance programs; and
        d. Penalties that may be imposed upon employees for drug abuse violations.
    3. Every employee who works on the proposed Agreement will:
        a. Receive a copy of the company's drug-free workplace policy statement; and
        b. Agree to abide by the terms of the company's statement as a condition of employment on the Agreement.

Failure to comply with these requirements may result in suspension of payments under the Agreement or termination of the Agreement or both, and Provider may be ineligible for award of any future State agreements if the department determines that any of the following has occurred: the Provider has made false certification, or violated certification by failing to carry out the requirements as noted above (Government Code Section 8350 et seq.)

E. Recordkeeping Requirements:
    1. The Provider shall retain, , as applicable, the following information: beneficiary grievance and appeal records in 42 CFR §438.416, and the data, information, and documentation

specified in 42 CFR §§438.604, 438.606, 438.608, and 438.610 for a period of no less than 10 years.

2. Provider shall ensure that all Provider sites shall keep a record of the beneficiaries/patients being treated at that location. Provider shall retain beneficiary records for a minimum of 10 years, in accordance with 438.3(h), from the finalized cost settlement process with the Department. When an audit by the Federal Government or DHCS has been started before the expiration of the 10-year period, the beneficiary records shall be maintained until completion of the audit and the final resolution of all issues.

F. Limitation on Use of Funds for Promotion of Legalization of Controlled Substances: None of the funds made available through this Agreement may be used for any activity that promotes the legalization of any drug or other substance included in Schedule I of Section 202 of the Controlled Substances Act (21 USC 812).

G. Federal Law Requirements:

1. Title VI of the Civil Rights Act of 1964, Section 2000d, as amended, prohibiting discrimination based on race, color, or national origin in federally funded programs.
2. Title IX of the education amendments of 1972 (regarding education and programs and activities), if applicable. iii. Title VIII of the Civil Rights Act of 1968 (42 USC 3601 et seq.) prohibiting discrimination on the basis of race, color, religion, sex, handicap, familial status or national origin in the sale or rental of housing.
3. Age Discrimination Act of 1975 (45 CFR Part 90), as amended (42 USC Sections 6101 – 6107), which prohibits discrimination on the basis of age.
4. Age Discrimination in Employment Act (29 CFR Part 1625).
5. Title I of the Americans with Disabilities Act (29 CFR Part 1630) prohibiting discrimination against the disabled in employment.
6. Americans with Disabilities Act (28 CFR Part 35) prohibiting discrimination against the disabled by public entities.
7. Title III of the Americans with Disabilities Act (28 CFR Part 36) regarding access.
8. Rehabilitation Act of 1973, as amended (29 USC Section 794), prohibiting discrimination on the basis of individuals with disabilities.
9. Executive Order 11246 (42 USC 2000(e) et seq. and 41 CFR Part 60) regarding nondiscrimination in employment under federal contracts and construction contracts greater than $10,000 funded by federal financial assistance.
10. Executive Order 13166 (67 FR 41455) to improve access to federal services for those with limited English proficiency. xii. The Drug Abuse Office and Treatment Act of 1972, as amended, relating to nondiscrimination on the basis of drug abuse.
11. The Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism.

H. State Law Requirements:

1. Fair Employment and Housing Act (Government Code Section 12900 et seq.) and the applicable regulations promulgated thereunder (California Administrative Code, Title 2, Section 7285.0 et seq.).
2. Title 2, Division 3, Article 9.5 of the Government Code, commencing with Section 11135.
3. Title 9, Division 4, Chapter 8, commencing with Section 10800.

4. No state or Federal funds shall be used by the Provider, for sectarian worship, instruction, and/or proselytization. No state funds shall be used by the Provider to provide direct, immediate, or substantial support to any religious activity.
5. Noncompliance with the requirements of nondiscrimination in services shall constitute grounds for state to withhold payments under this Agreement or terminate all, or any type, of funding provided hereunder.

I. Trading Partner Requirements:
1. No Changes. Provider hereby agrees that for the personal health information (Information), it shall not change any definition, data condition or use of a data element or segment as proscribed in the federal HHS Transaction Standard Regulation. (45 CFR Part 162.915 (a))
2. No Additions. Provider hereby agrees that for the Information, it shall not add any data elements or segments to the maximum data set as proscribed in the HHS Transaction Standard Regulation. (45 CFR Part 162.915 (b))
3. No Unauthorized Uses. Provider hereby agrees that for the Information, it shall not use any code or data elements that either are marked "not used" in the HHS Transaction's Implementation specification or are not in the HHS Transaction Standard's implementation specifications. (45 CFR Part 162.915 (c))
4. No Changes to Meaning or Intent. Provider hereby agrees that for the Information, it shall not change the meaning or intent of any of the HHS Transaction Standard's implementation specification. (45 CFR Part 162.915 (d))

J. Confidentiality (42 CFR §438.224): For medical records and any other health and enrollment information that identifies a particular beneficiary, the Provider shall use and disclose such individually identifiable health information in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E and 42 CFR Part 2, to the extent that these requirements are applicable.

K. Trafficking Victims Protection Act of 2000: Provider shall comply with Section 106(g) of the Trafficking Victims Protection Act of 2000 (22 U.S.C. 7104(g)) as amended by section 1702.

L. National Labor Relations Board Certification: Provider certifies that no more than one (1) final un-appealable finding of contempt of court by a Federal court has been issued against Provider within the immediately preceding two-year period because of Provider's failure to comply with an order of a Federal court, which orders Provider to comply with an order of the National Labor Relations Board (Public Contract Code Section 10296).

M. Domestic Partners: For contracts of $100,000 or more, Provider certifies that Provider is in compliance with Public Contract Code Section 10295.3.

N. Gender Identity: For contracts of $100,000 or more, Provider certifies that Provider is in compliance with Public Contract Code Section 10295.35.

O. Americans with Disabilities Act: Provider assures that it complies with the Americans with Disability Act (ADA) of 1990, which prohibits discrimination on the basis of disability, as well as all applicable regulations and guidelines issued pursuant to the ADA (42 U.S.C. 12101 et seq).

P. Prohibited Affiliations (42 CFR Section 438.610): The Provider shall not knowingly have a relationship of the type described in paragraph (iii) of this subsection with the following:
1. An individual or entity that is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from

participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.

2. An individual or entity who is an affiliate, as defined in the Federal Acquisition Regulation at 48 CFR 2.101, of a person described in paragraph (a)(1) of this section.
    a. The Provider shall not have a relationship with an individual or entity that is excluded from participation in any Federal Health Care Program under section 1128 or 1128A of the Act.
    b. The relationships described in paragraph (i) of this section, are as follows:
        i. A director, officer, or partner of the Provider.
        ii. A subcontractor (Provider) of the County, as governed by 42 CFR §438.230.
        iii. A person with beneficial ownership of five percent or more of the Provider's equity.
        iv. A network provider or person with an employment, consulting, or other arrangement with the Provider for the provision of items and services that are significant and material to the Provider's obligations under this Agreement.

Q. Sobky v. Smoley – Service Requirements: Provider, to the extent applicable, shall comply with "Sobky v. Smoley" (Document 2A), 855 F. Supp. 1123 (E.D. Cal 1994), incorporated by this reference.

ARTILCE XXXVIII – Counterparts

This Agreement may be executed in any number of counterparts and by the parties hereto in separate counterparts, each of which when so executed shall be deemed to be an original and all of which taken together shall constitute one and the same agreement.

ARTICLE XXXIX – Entire Agreement

This document and the documents referred to herein or exhibits hereto are the entire Agreement between the parties and they incorporate or supersede all prior written or oral Agreements or understandings.

Requesting Contract Administrator Concurrence:

By: Salina Drennan Dated: 3-2-2020

Salina Drennan
Substance Use Disorder Services Program Manager
Health and Human Services Agency

~~**IN WITNESS WHEREOF**~~, ~~the parties hereto have executed this Agreement #4206 on the dates indicated below~~.

~~-- COUNTY OF EL DORADO --~~

Requesting Department Head Concurrence:

By: _____ Dated: 3-31-20

Donald Semon
Director
Health and Human Services Agency
"~~County~~"

-- PROVIDER --

PROGRESS HOUSE, INC.
(A CALIFORNIA DOMESTIC NON-PROFIT CORPORATION)

By: _____ Dated: 3/4/20

Barbara Vermilyea
Executive Director
"Provider"

- - COUNTY of EL DORADO - -

Dated: _____

(aw/lk)

By: _____

Brian K Veerkamp, Chair
Board of Supervisors
"County"

ATTEST:
Kim Dawson
Clerk of the Board of Supervisors

By: _____ Dated: _____
Deputy Clerk